year shall be used to adjust RFR.

(a) Psychiatric Hospitals may demonstrate that increases in certain intensity factors between the base year and the intermediate year have led to increases in service intensity e.g., FTEs, nursing hours per patient), which in turn have led to quantifiable increases in cost. Intensity factors include, changes in: age mix, average length of stay, number of involuntary lockup patients, patient disability index, and percentage of patients admitted from an acute hospital. Note that increases in inputs alone are not enough to qualify for an intensity CBC; some intensity-related change in patient characteristics must also be identified.

(b) If the documentation for the increase in intensity is found to be acceptable then the hospital shall have the burden of documenting the increase in patient care costs resulting from the higher level of intensity.

(9) Costs for increases in physician malpractice insurance premiums paid by the hospital for physicians who are employees of the hospital and who do not bill patients or third-party reimbursers separately for their professional services. The amount of the approved exception allowance will be the net of all the increases already determined through the inflation allowance for malpractice insurance premiums from the base year forward and included in the hospital's Medicaid rates. The hospital must document the actual malpractice insurance premium expense, as well as show that the physicians covered are employees of the

hospital and do not bill separately for their services. The hospital may include in the CBC request the amount of any retroactive premium payments to be made during the rate year.

C. No costs other than those meeting the criteria set forth in one or more of the above categories shall constitute a cost beyond the reasonable control of the hospital.

6. New Services

(a) The DHCFP recognize as a new service any health services that were not offered by a hospital prior to the intermediate year. In order to be recognized as a new service by the DHCFP, the service to be provided should conform with the cost reporting requirements contained in 114.1 CMR 40.03. The DHCFP shall not approve any cost allowances for a new service that is not scheduled to start within six (6) months.

(b) For a new service to be implemented after the start of the hospital's rate year, the allowable cost shall be equal to the reasonable operating costs attributed to the new service cost centers. For a new service started in the base year, the allowable cost shall be equal to the reasonable base year cost attributed to the new service inflated by a base to rate year inflation factor plus a base to rate year allowance for volume adjustment attributed to the new service.

III.C. Determination of Capital Requirement:

The Capital Requirement consists of the sum of the allowed cost for depreciation on building and fixed equipment, plus the allowed cost for interest expenses, plus a return on base-year equity capital invested, as determined by the Principles of Reimbursement for Provider Costs under 42 U.S.C. ss. 1395 et seq. as set forth in 42 CFR 413 et seq. and the Provider Reimbursement Manual; except that, capital expenditures

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approved in connection with a Determination of Need project application pursuant to M.G.L. c. 111, §§25B - 25G shall not be allowed unless the project is scheduled to become operational within six months of the date of filing a budget review submission or charge modification application.

A non-state-owned psychiatric hospital's allowable capital requirement consists of the hospital's actual base year costs for historical depreciation for building and fixed equipment; reasonable interest expenses; amortization and; leases and rental of facilities. The capital requirement further includes incremental capital costs associated with approved CBCs and new services.

The base year capital requirement shall be adjusted to include reasonable projected acquisitions and retirements of fixed equipment and plant, and reasonable projected increases and decreases in amortization, leases and rentals, subject to the limitations contained in 114.1 CMR 40.07(3).

III.D. Determination of Reasonable Financial Requirements (RFR) for the Rate Year:

For hospitals with fiscal years beginning on or after October 1, 1996, Reasonable Financial Requirements (RFR) shall be equal the total of the Operating Requirement, determined according to Section III.B.2 herein, the Capital Requirement, determined according to Section III.C. herein, and a working capital requirement that is calculated by multiplying the sum of the operating requirement and the capital requirement by .0055.

III.E. Determination of Approved Gross Patient Service Revenue for the rate Year:

For the rate year beginning October 1, 1996, a non-state-owned psychiatric hospital's GPSR shall be the GPSR approved by the DHCFP for the prior year ending September 30, 1996, in accordance with the provisions of 114.1 CMR 40.04(4)(b).

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III.F. New Hospitals

For hospitals which were not licensed and/or operated as a non-acute hospital in FY 1993 or did not report a full year of actual costs in FY 1993, the base year for operating and capital costs shall be the year used in the hospital's first RFR calculation.

If the base year RFR was not based on a full year of actual costs, the DHCFP shall determine whether to utilize the base year RFR information , establish a different base year in accordance with Medicare regulations at 42 CFR 413.40(f)(1)(i), or to evaluate the hospital's projected operating and capital costs for reasonableness. The criteria for such review will include, peer group analysis of costs incurred by comparable facilities.

For a new hospital where base year RFR information is not used, the DHCFP shall make any necessary adjustments according to the provisions of 114. CMR 40.07 and 114.1 CMR 40.08 to reflect the use of a different data source.

For new hospitals, which were not licensed and/or operated as non-acute hospitals in FY 1996, or did not have a base year previously established, the base year for operating and capital cost shall be the first full year of hospital cost pursuant to 114.1 CMR 40.06. If the DHCFP determines that the data source is inadequate or not representive of the hospital's ongoing costs, the Division may consider alternative data sources to determine Base Year costs. Criteria for such review will include but will not be limited to peer group analysis of costs incurred and the determination of approved rates for comparable facilities.

For FY 1997, the PAF shall be based upon projected cost determined by 114.1 CMR 40.09(1)(d) and projected GPSR. The projected GPSR shall be reviewed by the DHCFP for reasonableness against the Charge per Medicaid Inpatient Day for comparable facilities.

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III.G. Rates of Payment for Medicaid Services

1. For all non-state-owned Psychiatric Hospital services, the Medicaid rate of payment shall be equal to the payment-on-account factor (PAF) multiplied by the approved charge for each eligible service provided to a publicly aided individual under the Medicaid program. Each PAF is hospital-specific and is computed by dividing the RFR, as determined pursuant to Section III.D. herein, by the approved GPSR, as determined pursuant to Section III.E. herein. The PAF shall not exceed 100%.

2. The PAF may be adjusted by the DHCFP based upon information filed by a non-state-owned psychiatric hospital on the DHCFP-450 Form. The adjustment to the PAF shall be made by the DHCFP in accordance with 114.1 CMR 40.04 (4)(b) whenever the reported charge per day of a non-state-owned psychiatric hospital on the DHCFP Form increases beyond the allowable increase specified in 114.1 CMR 40.04(4)(b)(2). The purpose of the adjustment is to avoid excessive payments to non-state-owned psychiatric hospitals that could be occasioned by increases in hospital charges due to deregulation of charges.

IV. PAYMENT ADJUSTMENT FOR DISPROPORTIONATE SHARE HOSPITALS

None of the Non-State-Owned psychiatric hospitals in the Commonwealth offer obstetric services. In accordance with Section 1923 of the Social Security Act (42 U.S.C. 1396r-4), the Commonwealth will make payment adjustments to nonacute hospitals which serve a disproportionate number of low-income patients. Eligibility requirements and the methodology for calculating the adjustment are described below.

IV.A. Determination of Eligibility

A Non-State-Owned psychiatric hospital is eligible for a disproportionate-share adjustment if:

1. the hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state; or

2. the hospital's low-income utilization rate exceeds twenty-five (25) percent and,

3. to qualify for any type of disproportionate payment adjustment, a hospital must have a medicaid,inpatient utilization rate, calculated by dividing Medicaid patient days by total patient days, of not less than one percent (1%).

IV.B. Payment Adjustment

1. The total of all disproportionate share payments awarded to a particular hospital under this section shall not exceed the costs incurred during the year of furnishing hospital services to individuals who either are eligible for Medicaid or have no health insurance or source of third party coverage, less payments by Medicaid and by uninsured patients.

   (a) The total amount of funds allocated for payment to Nonacute hospitals including Psychiatric, Chronic/Rehabilitation, and State-Owned Nonacute hospitals under the federally-mandated Medicaid disproportionate share adjustment requirement shall be $150,000 per year.

2. The total amount of funds to be allocated for each year will be distributed amongst the qualifying Non-State-Owned Psychiatric Hospitals for that year, in

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accordance with the determination of eligibility described in Section IV. A. above. The distribution of these funds will be made according to the following methodology: For each hospital which qualifies under 1.a. above:

(a) the relative ratio of a hospital's Medicaid inpatient utilization rate to one standard deviation of the mean Medicaid inpatient rate for hospitals receiving Medicaid payments in the state will be calculated;

(b) a Non-State-Owned Psychiatric Hospital's relative ratio as determined above will be multiplied by a base amount in order to determine the payment adjustment amount for that nonacute hospital. The base amount shall be calculated such that the distribution of funds among qualifying hospitals under Section IV.A above, shall equal the amount specified in Section IV.B.1.a.

Example: The mean Medicaid inpatient utilization rate in the state is 0.45 with a standard deviation (std) of .07. No hospital shall be eligible unless the criterion set forth section IV A. above are met.

(A) Qualifying Hospitals	(B) Medicaid Inp. Util. Rate	(C)** Ratio of Hosp. Med. Util. Rate to Mean plus std*	Payment Adjustment
A	0.55	1.0577	10,275.02
B	0.60	1.1538	11,208.58
C	0.69	1.3270	12,891.13
D	0.71	1.3654	13,264.16
		TOTAL:	$47,638.89

* Mean (0.45) + std (.07) = 0.52.

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** FY 1989 base amount equals $8,468.98; FY 1990 base amount equals $16,937.96; FY 1991 base amount equals $25,406.94 FY 1992 base amount equals $14,571.74; FY 93 base amount equals $9,714.49

o for each hospital which qualifies under IV A (ii) but not IV A (i) above:

A base amount of the total allocated amount specified in a. above, plus an additional amount, calculated on the base and proportionate to the amount that such hospital's low income utilization rate exceeds twenty-five percent, shall be determined.

Example: Five hospitals' low-income utilization rates are at or above 25% and such hospitals do not qualify under IV A (i) above. One hospital's low income utilization rate is 25%, while the rest exceed the 25% rate.

(1) Qualifying Hospitals	(2) Low Income Util. Rate	(3) Ratio of Low Inc. Util.Rate	(4) Payment Adjustment*
A	.25	1.00	$14,571.74
B	.26	1.01	14,717.45
C	.31	1.06	15,446.04
D	.40	1.15	16,757.50
E	.42	1.17	17,048.93
			$78,546.66

* FY 1992 base amount equals $14,571.74

** Total for hospitals qualifying under either IV A (i) or (ii) equals $150,000 as specified in IV A 1. If the hospital qualifies under both criteria no additional payment is make beyond what the hospital receives pursuant to the first criterion.

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IV. C. Pediatric Outlier: For Infants Under One Year of Age

1. In accordance with section 1902 of the act as amended by Section 4604 of OBRA 90, effective July 1, 1991, the Commonwealth will make an annual payment adjustment to Non-State-Owned psychiatric hospitals for inpatient hospital services furnished to infants under one year of age involving exceptionally high costs or exceptionally long lengths of stay.

2. Determination of Eligibility. Determination of eligibility for infants under one year of act shall be made as follows:

a. Exceptionally long lengths of stay.

(i) First calculate the statewide weighted average Medicaid inpatient length-of-stay. This shall be determined by dividing the sum of Medicaid days for all Non-State-Owned psychiatric hospitals in the state.

(ii) Second, calculate the statewide weighted standard deviation for Medicaid inpatient length-of-stay statistics.

(iii) Third, add one and one-half times the state wide weighted standard deviation for Medicaid inpatient length-of-stay to the state wide weighted average Medicaid inpatient length-of-stay. Any stay equal to or lengthier than the sum of these two numbers shall constitute and exceptionally long length-of-stay for purposes of payment adjustments under this section.

b. Exceptionally High Cost. For each Non-State-Owned Psychiatric hospital providing services on or after July 1, 1991 to individuals under one year of age the Commonwealth shall:

(i) First, calculate the average cost per Medicaid inpatient discharge for each hospital;

(ii) Second, calculate the standard deviation for the cost per Medicaid inpatient discharge for each hospital;

(iii) Third, add one and one-half times the hospital's standard deviation for the cost per Medicaid inpatient discharge to the hospital's average cost pe Medicaid inpatient discharge. Any cost which equals or exceeds the sum of these two numbers shall constitute an exceptionally high cost for purposes of payment adjustments.

(a) The amount of funds allocate shall be twenty five thousand dollars ($ 25,000) for FY 1997. This includes Psychiatric, Chronic/Rehabilitation, and State-Owned Nonacute hospitals.

(b) Any Hospital which qualifies for a payment adjustment for infants under one shall receive one percent of the total funds allocated for such payments. In the event that the payments to qualifying Non-State-Owned Psychiatric Hospitals would exceed the total, each share shall be proportionately reduced to stay within the allocation.

IV. D. Children Under Six

1. Eligibility for Payment. Consistent with section 4604 of the Omnibus Reconciliation Act of 1990 (OBRA 90) outlier adjustments for medically necessary inpatient hospital services , effective July 1, 1991, involving exceptionally high costs or exceptionally long lengths of stay, are extended to serv ices for children who have not reached the age of six, if provided by a hospital which qualifies as a disproportionate share hospital under Section 1923 (a) of the Social Security Act.

2. Amount of Payment Adjustment

a. The amount of funds allocate shall be twenty five thousand dollars ($ 25,000) for FY 1993. This includes Psychiatric, Chronic/Rehabilitation, and State-Owned Nonacute hospitals

b. Any Hospital which qualifies for a payment adjustment for children under six, pursuant to IV.D.1.) above shall receive one percent of the total funds allocated for such payments. In the event that the payments to qualifying Nonacute privately owned Non-State-Owned Psychiatric hospitals would exceed the total, each share shall be proportionately reduced to stay within the allocation.

IV.E. Extraordinary Disproportionate Share Adjustment for Psychiatric Hospitals

In accordance with 1923 (C)(3) of the Social Security Act (42 U.S.C. 1936r-4), effective October 31, 1992, the Commonwealth provides for an extraordinary disproportionate share adjustment for all eligible Psychiatric Hospitals. The following is a detailed description of the methodology to be used to determine the eligibility for the extraordinary disproportionate share adjustment.

1. Determination of Eligibility

In order to be eligible for an extraordinary disproportionate share payment adjustment, a non-State-Owned Psychiatric Hospital must:

(a) specializes in providing psychiatric/psychological care and treatment;

(b) provide for special active treatment such as treatment of deafness, developmental disabilities, and the elderly;

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(c) accepts all patients without regard for the ability to pay;

(d) consists partly or wholly of locked wards;

(e) meets requirements for the receipt of federal matching funds;

(f) has a low-income utilization rate that exceeds 45%; and

(g) has 50% or more of its costs that are not reimbursed.

2. Determination of Eligibility Under the Low-Income Utilization Method

(a) Data Source -- the FY 1994 RSC-403 report shall be used to determine the cost, free care, charge, patient day, and net revenue amounts. If said RSC-403 report is not available, the Commonwealth shall use the most recent available previous RSC-403 report to estimate these variables. If the specified data source is unavailable, then the Commonwealth shall determine and use the best alternative data source.

(b) Low-Income Standard

(i) For each psychiatric hospital, the Commonwealth shall calculate the hospital-specific low-income utilization rate as follows:

- o divide each psychiatric hospital's Medicaid revenue by its total gross patient service revenue; and
- o divide each psychiatric hospital's free care charges by its total charges.

- o The total of these percentages shall equal the low-income utilization rate.

(ii) If the hospital-specific low-income utilization rate exceeds 45%, then the psychiatric hospital meets the low-income standard.

3. Unreimbursed Cost Standard

a. For each psychiatric hospital, the Commonwealth shall calculate the hospital-specific unreimbursed cost percentage as follows:

(i) calculate the costs of providing hospital services to Medicaid-eligible individuals and uninsured individuals by multiplying RFR by the ratio of Medicaid and uninsured individuals to total charges.

(ii) Subtract the total of Medicaid payments (excluding any disproportionate share payment) plus payments by uninsured individuals from costs described in section IV.E.3.a.i, above to determine the amount of unreimbursed costs.

(iii) divide the amount of unreimbursed costs by the costs described in section IV.E.3.a.i. above to determine the percentage of unreimbursed costs.

b. If the hospital-specific percentage of unreimbursed costs exceed 50%, then the psychiatric hospital meets the unreimbursed cost standard.

4. Determination of Payment Amount

a. For each non-State-Owned Psychiatric Hospital determined eligible for an extraordinary

disproportionate share adjustment, the payment amount shall be equal to the estimated rate year unreimbursed cost of providing hospital services to Medicaid-eligible and uninsured individuals, calculated as follows:

(i) First determine the estimated budget year cost of providing hospital services to Medicaid eligible individuals and uninsured individuals, by using the formula described in section IV.E.3.a.i. above and substituting budget year RFR for the 1994 RFR that was used in section IV.E.3.a.i. above.

(ii) Then, multiply the budget year cost described in section IV.E.4.a.i. above by the percentage of unreimbursed costs described in section IV.E.3.a.iii. above.

b. Any payment for an extraordinary disproportionate share adjustment is subject to the limitation that the total of all disproportionate share payments awarded to a particular psychiatric hospital, including the Extraordinary Disproportionate Share Adjustment, shall not exceed the costs incurred during the year of furnishing hospital services to individuals who either are eligible for Medicaid or have no health insurance or source of third party coverage, less payment by Medicaid and by uninsured patients.

IV.F. Commonhealth Program Disproportionate Share Adjustment

Hospitals eligible for this adjustment are those non-acute facilities that incur costs for providing services pursuant to the Commonhealth program to certain low-income disabled individuals who are covered by a wholly state-financed program of medical assistance of the Division of Medical Assistance, as defined in the Division's regulations at 130 CMR 490.000 and 130 CMR 510.000 - 515.000 (attached). The payment amounts for eligible hospitals

receiving payments pursuant to the Commonhealth program are determined and paid on a periodic basis by the Division of Medical Assistance in accordance with its regulations at 130 CMR 490.000 and 130 CMR 510.000 - 515.000. The statutory authority is found at MGL c. 118E ss 16 and 16A (See Appendix).

V. OTHER ADJUSTMENT PROCESSES

The PAF for a non-State-Owned Psychiatric Hospital may also be adjusted by the following processes:

V.A. Administrative Adjustment

1. A hospital may apply at any time during the rate year for an administrative adjustment if there has been an arithmetic error in the calculation of its PAF.

2. A hospital may apply at any time during the first nine months of the rate year for an administrative adjustment based on a request for a CBC or a New Service adjustment to the PAF.

3. Within 60 days from receipt of a complete and satisfactory application for an administrative adjustment, the DHCFP will render a decision. A statement of reasons will be provided upon request.

V.B. Administrative Review

1. Purpose of Administrative Review

   To assure that a hospital's rates are in continuing compliance with this part, the DHCFP, may at any time and upon its own motion, review the rates upon notice to the hospital.

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2. Administrative Review of Transfers of Costs

Where a hospital has reduced or increased costs by transfer of those costs to or from other persons or entities which provide health care and services, the DHCFP may modify approved rates to reflect change in cost.

3. Administrative Review and Decision.

Upon notice of administrative review, a hospital shall submit such books, records, documentation, and information as the DHCFP may require. After review, the DHCFP will render a written decision and a statement of reasons for its decision.

V.C. Appeal

A non-State-Owned Psychiatric Hospital which is aggrieved by an action or failure to act under 114.1 CMR 40.00 may file an appeal within thirty (30) days to the Division of Administrative Law Appeals pursuant to the requirements of M.G.L. c. 118 G. The pendency of an appeal does not limit the DHCFP's rights to undertake administrative review of charges.

The Commonwealth's Budget Reform and Control Act of Chapter 653, Act of 1989, Section 84

The Division of Medical Assistance shall review, and approve or disapprove, any change in rates or in rate methodology proposed by the DHCFP. The Division of Medical Assistance shall review such proposed rate changes for consistency with its policy and federal requirements, and with the available funding authorized in the final budget for each fiscal year prior to certification of such rates by the DHCFP; provided, that the Division of Medical Assistance shall not disapprove a rate increase solely based on the availability of funding if the Federal Health Care Finance Administration provides written documentation that federal reimbursement would be denied as a result of said disapproval and said documentation is submitted to the House and Senate Committees on Ways and Means. The Division of Medical Assistance shall, whenever it disapproves a rate increase, submit the reasons for disapproval to the DHCFP together with such recommendations for changes. Such disapproval and recommendations for changes, if any, shall be submitted to the DHCFP after the Division of Medical Assistance is notified that the DHCFP intends to propose a rate increase for any class of provider under Title XIX but in no event later than the date of the public hearing held by the DHCFP regarding such rate change; provided that no rates shall take effect without the approval of the Division of Medical Assistance. The DHCFP and the Division of Medical Assistance shall provide documentation on the reasons for increases in any class of approved rates that exceed the medical component of the consumer price index to the House and Senate Committees on Ways and Means. The DHCFP shall supply the Division of Medical Assistance with all statistical information necessary to carry out the Division of Medical Assistance's review responsibilities under this Section. Notwithstanding the foregoing, the Division of Medical Assistance shall not review, approve, or disapprove any such rate set pursuant to Chapter Twenty-Three of the Acts of Nineteen Hundred and Eighty-Eight.

If projected payments from rates necessary to conform to applicable requirements of Title XIX are estimated by the Division of Medical Assistance to exceed the amount of funding appropriated for such purpose in the budget for such fiscal year, the Division of Medical Assistance and the DHCFP shall jointly prepare and submit to the Governor a proposal for the minimum amount of supplemental funding necessary to satisfy the requirements of the State Plan developed by the Division of Medical Assistance under Title XIX of the Federal Social Security Act.

114.1 CMR 40.00 NON-ACUTE HOSPITAL PUBLICLY ASSISTED RATES OF PAYMENT AND THE FEE FOR RESIDENTIAL ALCOHOLISM TREATMENT PROGRAMS

Section

40.01: General Provisions

(1) Scope, Purpose and Effective Date. The purpose of 114.1 CMR 40.00 is to set forth regulations for the establishment of certain non-acute hospital publicly assisted rates of payment, and the fee for residential alcoholism treatment programs. 114.1 CMR 40.00 shall be effective on October 1, 1996. 114.1 CMR 40.00 shall not apply to chronic/rehabilitation hospitals governed by 114.1 CMR 39.00. 114.1 CMR 40.00 shall not apply to managed care services provided to Medicaid recipients who are inpatients of a non-acute hospital under a direct contract with the Division of Medical Assistance.

(2) Authority. 114.1 CMR 40.00 is adopted pursuant to M.G.L. c. 118G; and M.G.L. c. 30A, s.2.

40.02: Definitions

As used in 114.1 CMR 40.00, unless the context requires otherwise, terms shall have the meanings ascribed in 114.1 CMR 40.02.

Adjusted Base Year Volume. The actual base year volume adjusted to include the volume associated with recurring CBCs, new services and transfers on of cost and exclude volume associated with discontinued services and transfers off of cost.

Administrative Day. An inpatient day spent in a non-acute hospital or public health care facility, other than a hospital operated by the Department of Mental Health (except facilities which are certified to provide services under Title XIX of the Social Security Act), by a patient who has been identified by a Professional Standards Review Organization (where applicable) or otherwise by the Division of Medical Assistance or by the Department of Public Health, or any combination of these organizations as a patient which does not require a hospital level of care.

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